

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Infant Boy Alvey		4. DATE OF DEATH Month 6 / Day 30 / Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1960
9. AGE (In years last birthday) 0 yrs 0 Months 0 Days 7 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonard Jackson Alvey		14. MOTHER'S MAIDEN NAME Lois Ann Guy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Leonard J. Alvey - Leonardtown, Md.	
17. INFORMANT Leonard J. Alvey - Leonardtown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 754.5 Congenital heart malformation (patent foramen ovale) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30 1960 , to June 30 1960 , that I last saw the deceased alive on June 30 1960 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P.J. Bean M.D.		ADDRESS (Street, city or town, state) Great Mills, Md. DATE SIGNED 6/30/60	
PHYSICIAN'S NAME (Type) P.J. Bean, MD		Great Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/1/60	22c. NAME OF CEMETERY OR CREMATORY St. Aloysius Cem.	22d. LOCATION (City, town, or county) (State) Leonardtwn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2078203XV3

CERTIFICATE OF DEATH

1911

1911

FILED IN

DEPT. OF HEALTH

Blank form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07297
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's <div style="text-align: center;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNAS, Station Hospital				d. STREET ADDRESS Patuxent River, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Pierre Middle George Last ARNOLD				4. DATE OF DEATH Month June Day 7 Year 19 60				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-8-32		
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crash Crew			10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Douglas John KELM				14. MOTHER'S MAIDEN NAME Florence Pligye LEACH				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 7-50 6-60 469 20 0243		17. INFORMANT Official U.S. Navy Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 864x INJURIES, MULTIPLE, EXTREME IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crash Crew - struck by aircraft debris					
20c. TIME OF INJURY Month, Day, Year 3:50 a.m. June 7 1960			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) USNAS, Patuxent River, Md		20f. (City or town) (County) (State) St. Mary's, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Wm. D. BOYD, MD				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-9-60		22c. NAME OF CEMETERY OR CREMATORY Shakopee, Minn.		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland		24a. REC'D BY REGISTRAR JUN 13 60		
				24b. REGISTRAR'S SIGNATURE Arthur S. Brand		DATE		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G266 7-5-60 et

Reg. Dist. No. 07298

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE New York b. COUNTY Long Island	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville Rural		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Walter Last Barresi		4. DATE OF DEATH Month June Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 13, 1917
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 4 Days 13 Hours 3 Min.	IF UNDER 24 HRS. Months 4 Days 13 Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grumman Aircraft		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthonino Barresi		14. MOTHER'S MAIDEN NAME Josephine Movearo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Florence Barresi	
17. INFORMANT Florence Barresi		Address 12 Wild Wood Lane Smith Town, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auto Accident			
INTERVAL BETWEEN ONSET AND DEATH Immed.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident	
20c. TIME OF INJURY Month, Day, Year 6/22 19 60 Hour 4 a. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md St. Rt 235	20f. (City or town) (County) (State) Mechanicsville, St. Mary's Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William D. Boyd M.D.		DATE SIGNED 6/22/60	
EXAMINER'S NAME (Type) William D. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition Buried	22b. DATE THEREOF 6/27/60	22c. NAME OF CEMETERY OR CREMATORY National Pine Lawn	22d. LOCATION (City, town, or county) (State) New York
23. FUNERAL DIRECTOR'S SIGNATURE Orlando R. Davis		24a. REC'D BY REGISTRAR DATE JUN 24 '60	
ADDRESS Smithtown, Long Island New York		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Physician		11. Signature of Nurse		12. Signature of Undertaker	
13. Signature of Witness		14. Signature of Juror		15. Signature of Juror		16. Signature of Juror	
17. Signature of Juror		18. Signature of Juror		19. Signature of Juror		20. Signature of Juror	
21. Signature of Juror		22. Signature of Juror		23. Signature of Juror		24. Signature of Juror	
25. Signature of Juror		26. Signature of Juror		27. Signature of Juror		28. Signature of Juror	
29. Signature of Juror		30. Signature of Juror		31. Signature of Juror		32. Signature of Juror	
33. Signature of Juror		34. Signature of Juror		35. Signature of Juror		36. Signature of Juror	
37. Signature of Juror		38. Signature of Juror		39. Signature of Juror		40. Signature of Juror	
41. Signature of Juror		42. Signature of Juror		43. Signature of Juror		44. Signature of Juror	
45. Signature of Juror		46. Signature of Juror		47. Signature of Juror		48. Signature of Juror	
49. Signature of Juror		50. Signature of Juror		51. Signature of Juror		52. Signature of Juror	
53. Signature of Juror		54. Signature of Juror		55. Signature of Juror		56. Signature of Juror	
57. Signature of Juror		58. Signature of Juror		59. Signature of Juror		60. Signature of Juror	
61. Signature of Juror		62. Signature of Juror		63. Signature of Juror		64. Signature of Juror	
65. Signature of Juror		66. Signature of Juror		67. Signature of Juror		68. Signature of Juror	
69. Signature of Juror		70. Signature of Juror		71. Signature of Juror		72. Signature of Juror	
73. Signature of Juror		74. Signature of Juror		75. Signature of Juror		76. Signature of Juror	
77. Signature of Juror		78. Signature of Juror		79. Signature of Juror		80. Signature of Juror	
81. Signature of Juror		82. Signature of Juror		83. Signature of Juror		84. Signature of Juror	
85. Signature of Juror		86. Signature of Juror		87. Signature of Juror		88. Signature of Juror	
89. Signature of Juror		90. Signature of Juror		91. Signature of Juror		92. Signature of Juror	
93. Signature of Juror		94. Signature of Juror		95. Signature of Juror		96. Signature of Juror	
97. Signature of Juror		98. Signature of Juror		99. Signature of Juror		100. Signature of Juror	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7316

CERTIFICATE OF DEATH

07299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANN Middle MORGAN Last BROWN				4. DATE OF DEATH Month June Day 26 Year 19 60			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/1885	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph F. Morgan				14. MOTHER'S MAIDEN NAME Ellen Leigh Edelen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT R. Bascom Brown, Jr. - Leonardtown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of the pelvis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 2 06-22 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Leonardtwn Maryland	
21. I certify that I attended the deceased from 6-22 , 19 60 to 6-26 , 19 60 , that I last saw the deceased alive on 6-26 , 19 60 , and that death occurred at 10:30 P. M. from the causes and on the date stated above.							DATE SIGNED 6/27/60
ACTUAL SIGNATURE A. Samadi M.D.				ADDRESS (Street, city or town, state) Leonardtwn, Md.			
PHYSICIAN'S NAME (Type) A. Samadi, MD				Leonardtwn, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/60		22c. NAME OF CEMETERY OR CREMATORY St. Aloysius Cemetery		22d. LOCATION (City, town, or county) (State) Leonardtwn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE JUL 5 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0250

WEST VIRGINIA DEPARTMENT OF HEALTH - BUREAU OF VITALS

CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for name, date, and cause of death.

WEST VIRGINIA DEPARTMENT OF HEALTH - BUREAU OF VITALS

WEST VIRGINIA DEPARTMENT OF HEALTH - BUREAU OF VITALS

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7326

FilmG267 7-19-60 et

Reg. Dist. No.

07300

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mississippi</u> b. COUNTY <u>? 61X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>USNAS, PATUXENT RIVER</u>		c. LENGTH OF STAY IN 1b <u>0</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>USNAS (Station Hospital)</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jackson</u>	
		d. STREET ADDRESS <u>372 Mason St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>A</u> Last <u>CHATHAM</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1935</u>
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Air Force</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clyde R. Chatham</u>		14. MOTHER'S MAIDEN NAME <u>Lottie A. (Last name unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>6-60</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INJURIES, MULTIPLE, EXTREME</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Air Crewman in helicopter struck by naval aircraft (F8U).</u>	
20c. TIME OF INJURY Hour <u>3:50</u> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/> Month, Day, Year <u>June 7 19 60</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>USNAS, Patuxent River, Md.</u>	20f. (City or town) (County) (State) <u>St. Mary's, Maryland</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S.D. Harmon</u> S.D. HARMON, LT MC USN, Station Hospital, USNAS, PATUXENT RIVER, MD		DATE SIGNED <u>7 June 1960</u>	
EXAMINER'S NAME (Type) <u>Wm. D. BOYD MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-13-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedarlawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Jackson Mississippi</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home, 816 H St., NE, Wash. 2</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEATH CERTIFICATE

DATE

TIME

PLACE

REGISTRATION NO.

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Date of death
7. Time of death
8. Place of death
9. Cause of death
10. Manner of death
11. Signature of physician
12. Signature of registrar

13. Signature of informant
14. Signature of witness
15. Signature of registrar
16. Signature of registrar

17. Signature of registrar
18. Signature of registrar
19. Signature of registrar
20. Signature of registrar

21. Signature of registrar
22. Signature of registrar
23. Signature of registrar
24. Signature of registrar

25. Signature of registrar
26. Signature of registrar
27. Signature of registrar
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29. Signature of registrar
30. Signature of registrar
31. Signature of registrar
32. Signature of registrar

33. Signature of registrar
34. Signature of registrar
35. Signature of registrar
36. Signature of registrar

37. Signature of registrar
38. Signature of registrar
39. Signature of registrar
40. Signature of registrar

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an agent is necessary, please execute the certificate, writing the word "pending" in pencil in item 15. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

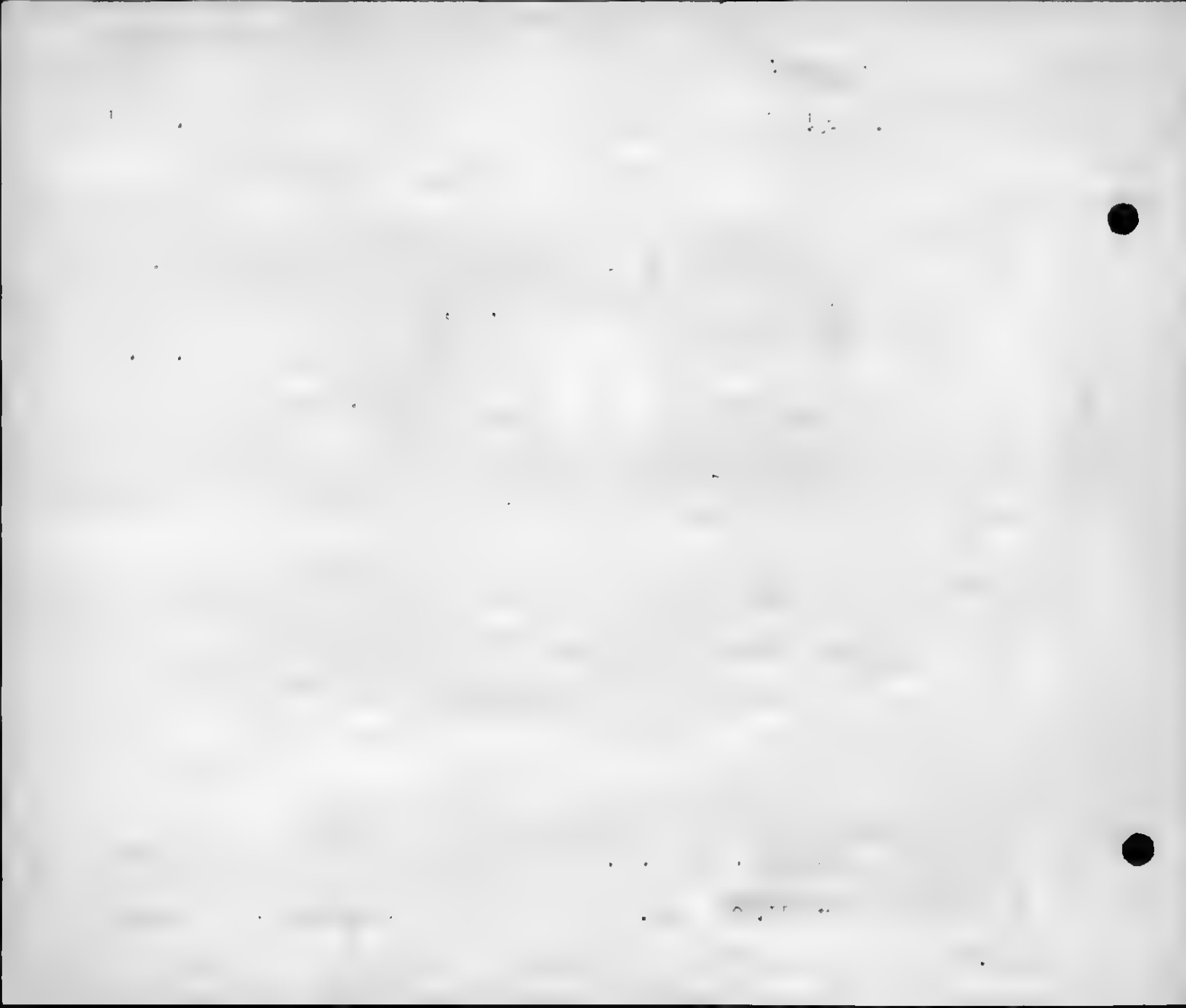
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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
7327 07301											
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leonardtown</u>					c. LENGTH OF STAY IN 1b <u>Life</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leonardtown</u>						
					d. STREET ADDRESS <u>1</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
			<u>Paul Elmer Connelly</u>			<u>June 9, 1960</u>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<u>Male</u>		<u>White</u>		<u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		<u>Oct. 17, 1924</u>		<u>35</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
<u>Clerk</u>				<u>Store</u>				<u>Maryland</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
<u>Fillmore Connelly</u>				<u>Mary M. Shore</u>				<u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
<u>Yes</u>				<u>578 26 1843</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HANGED</u>										<u>IMMED.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
										<u>Climbed up tree & hanged self with straps</u>	
20c. TIME OF INJURY			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
Hour a.m. <u>11:30</u> <u>6-4</u> 19 <u>60</u>			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			<u>FARM</u>			<u>LEONARDTOWN St. Mary's, Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>William D. Boyd M. D.</u> M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William D. Boyd M. D.</u>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
										DATE SIGNED <u>6/10/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										22b. DATE THEREOF <u>June 11, 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>										22d. LOCATION (City, town, or country) (State) <u>Leonardtown, Maryland</u>	
23. FUNERAL DIRECTOR ADDRESS <u>W. Clarke Mattingley Leonardtown, Maryland</u>										24a. REC'D BY REGISTRAR <u>JUN 20 '60</u>	
										24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	



may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. These places remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

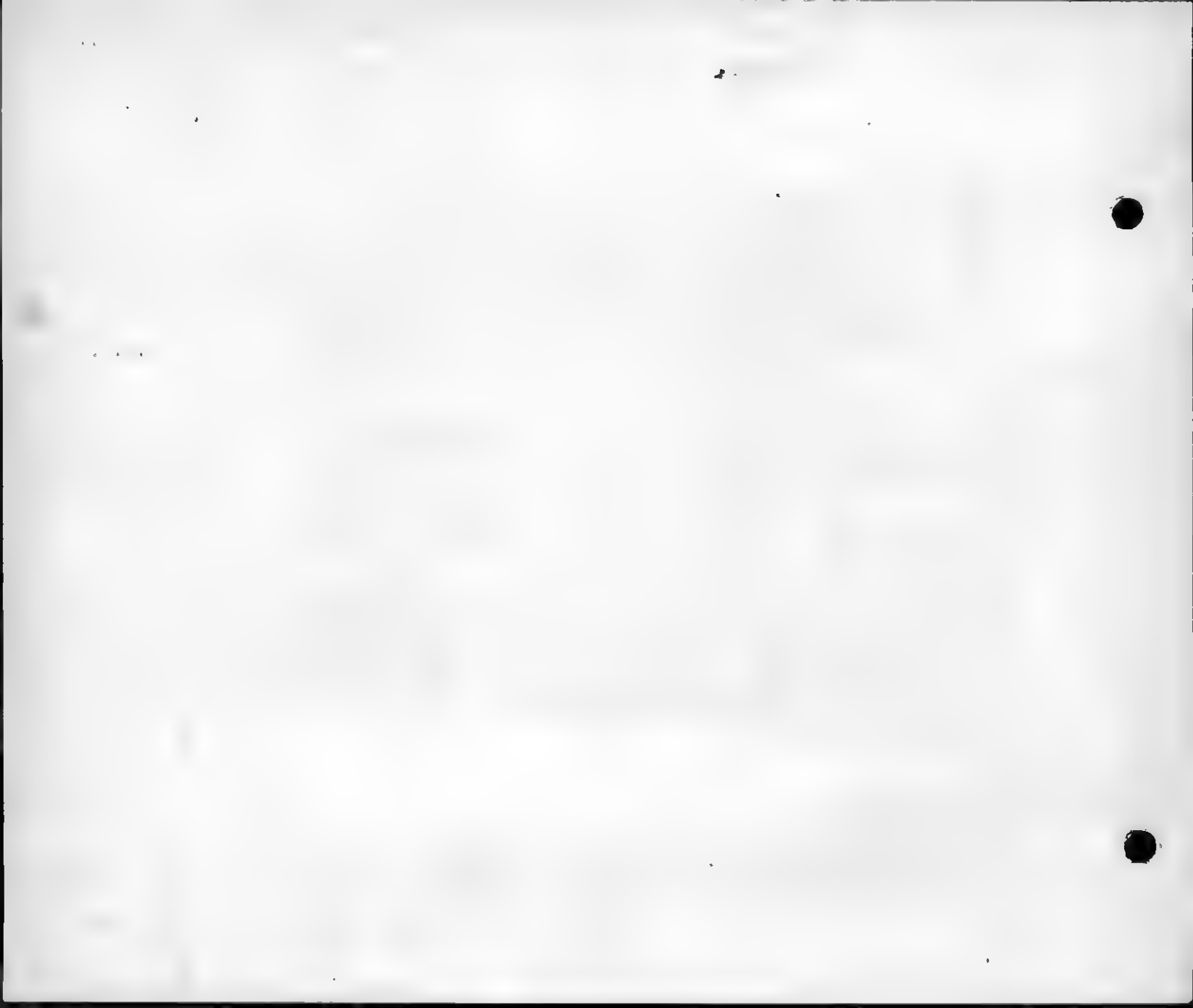
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Item 9 - 11-11-60 7-5-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown, Md				c. LENGTH OF STAY IN lb 16			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Park Hall			
3. NAME OF DECEASED (Type or print) First Mary Middle Last Curtis				4. DATE OF DEATH Month June Day 26 Year 19 60			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ? ? ? Approx.	
9. AGE (In years lost birthday) 80 yrs		F UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? ?				14. MOTHER'S MAIDEN NAME ? ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks 26 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 19 60 to June 26 60 that (I) (we) last saw the deceased alive on June 9 60 and that death occurred at 7 M. from the causes and on the date stated above.							
22a. SIGNATURE Ernest Rehm		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE 30 June 60			
22c. PHYSICIAN'S NAME (Type) Ernest Rehm M.D.		22d. ADDRESS Lexington Park					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/60		23c. NAME OF CEMETERY OR CREMATORY John Westley Cemetery		23d. LOCATION (City, town, or county) (State) Chaptico, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtown, Maryland		25a. REC'D BY REGISTRAR DATE JUL 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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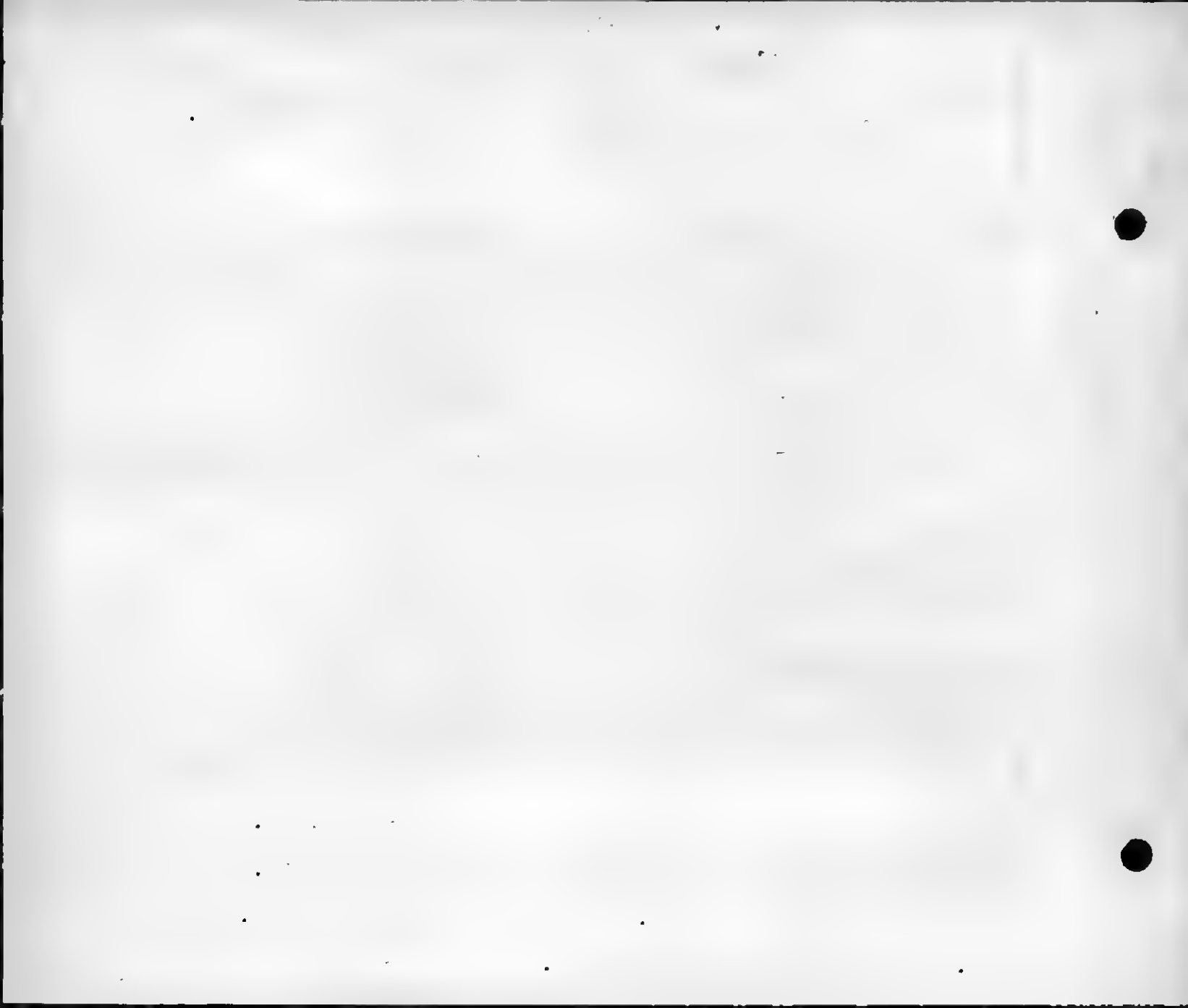
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge	
c. LENGTH OF STAY IN 1b 6 wks		d. STREET ADDRESS 1 Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PAUL THEOPHILUS DAVIS		4. DATE OF DEATH Month Day Year June 5 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 August 1899
9. AGE (In years last birthday) yrs 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Davis		14. MOTHER'S MAIDEN NAME Jennie Sayre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577 14 8762	
17. INFORMANT Susie R. Davis - Ridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute hemorrhage, post op., late (4w) DUE TO (b) abdominopelvic resection - 87m DUE TO (c) Ca of rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leonardtwn, Md. 6/6/60			
ACTUAL SIGNATURE Michael Barbarich M.D.		PHYSICIAN'S NAME (Type) Michael Barbarich, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/60	
22c. NAME OF CEMETERY OR CREMATORY St. Michaels		22d. LOCATION (City, town, or county) (State) Ridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE JUN 10 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07304

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

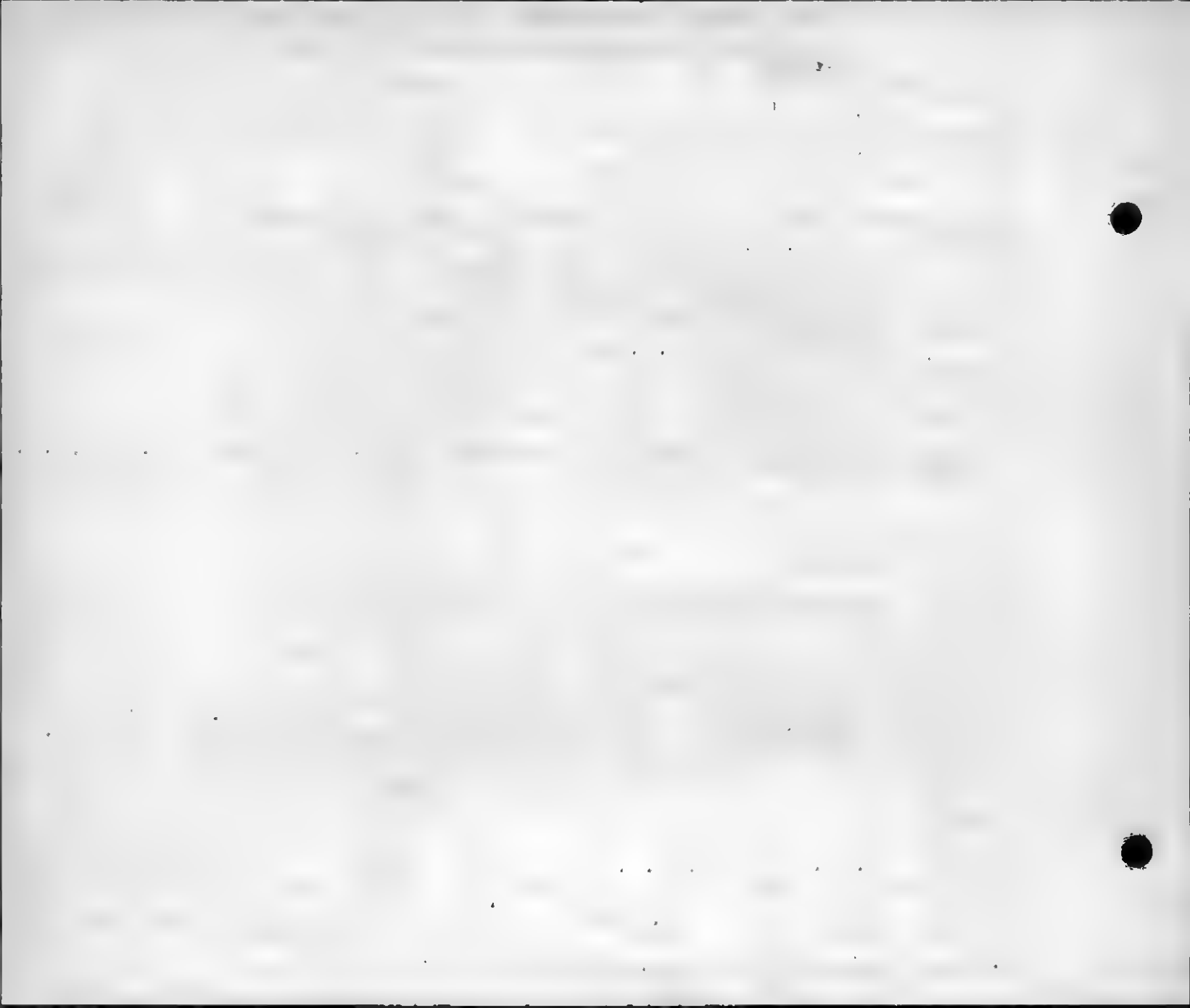
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE New Jersey b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Lexington Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deal	
c. LENGTH OF STAY IN lb Temporary		d. STREET ADDRESS 105 Poplar Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Jefferson EBERLE		4. DATE OF DEATH Month Day Year June 1 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 April 1934
9. AGE (in years) 26 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Army		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army Sp4	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Joseph Eberle		14. MOTHER'S MAIDEN NAME Mary Kathleen Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) Not	
17. INFORMANT Wife:		Address Angelina Eberle, 105 Poplar Ave, Deal, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Skull Fracture & Fracture Neck DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Auto Accident	
20c. TIME OF INJURY Month, Day, Year 2:00 p. m. June 1, 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Willow Road	20f. (City or town) (State) St. Mary's, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>W. H. Patrick</i>		DATE SIGNED 2 June 1960	
EXAMINER'S NAME (Type) W. H. PATRICK, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/6/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	22d. LOCATION (City, town, or county) (State) Long Branch, New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE JUN 6 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>

MEDICAL CERTIFICATION

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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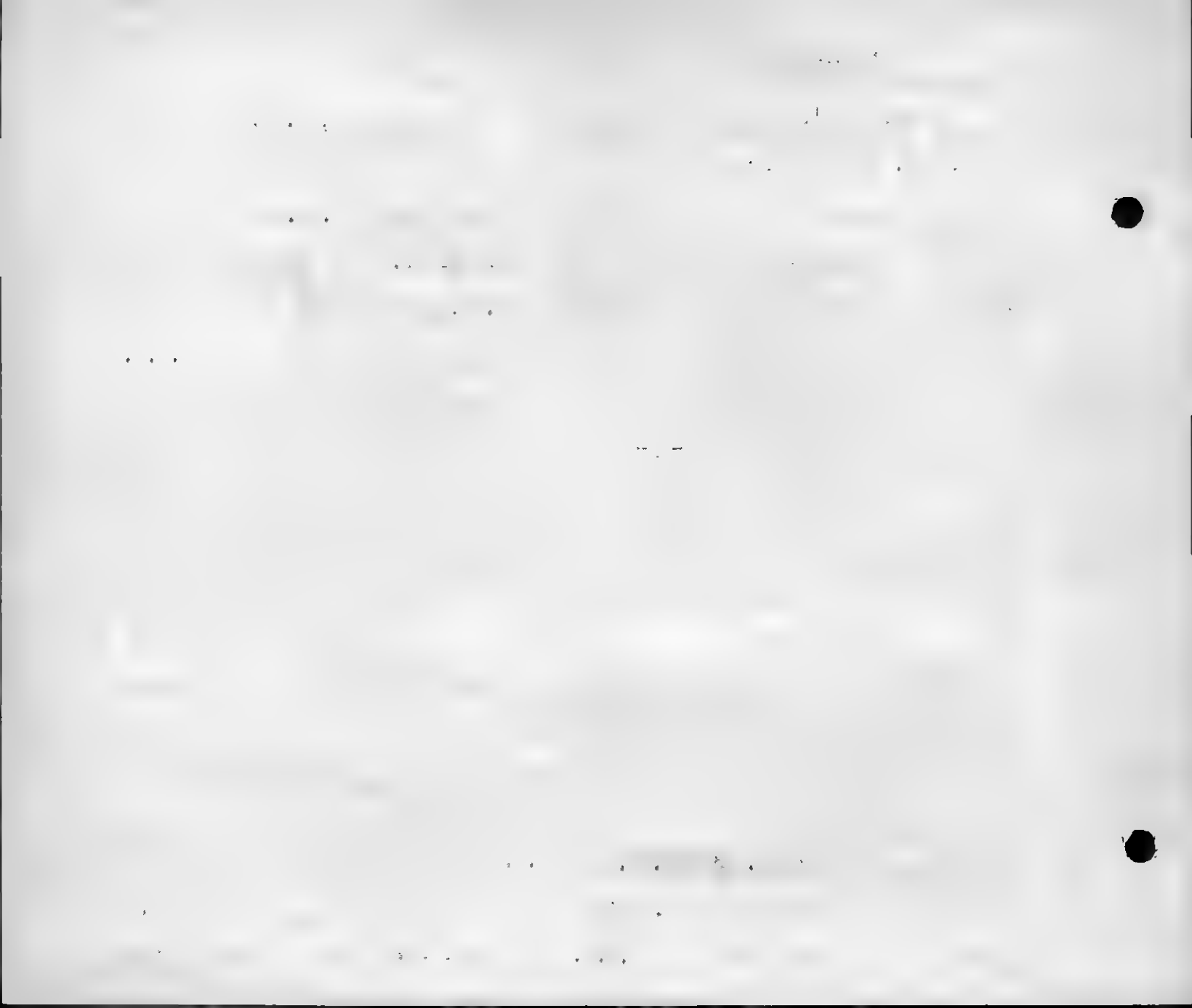
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Inigoes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		e. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) CECELIA B. GREEN		4. DATE OF DEATH Month June Day 18 Year 19 60	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1884
9. AGE (In years birth day) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar Biscoe		14. MOTHER'S MAIDEN NAME Nora Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Sarah Ramsey- 102 Kearney Ave. Jersey City N.J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerosis DUE TO (c) 10-20 yrs		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured Femur			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 June 1960 to 18 June 1960 , that I last saw the deceased alive on 16 June 1960 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest M. Rehm M.D.		ADDRESS (Street, city or town, state) Lexington Park, Md. DATE SIGNED 22 June 60	
PHYSICIAN'S NAME (Type) Ernest M. Rehm, MD		ADDRESS Lexington Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/22/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	22d. LOCATION (City, town, or county) (State) St. Inigoes, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson- Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE JUN 27 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

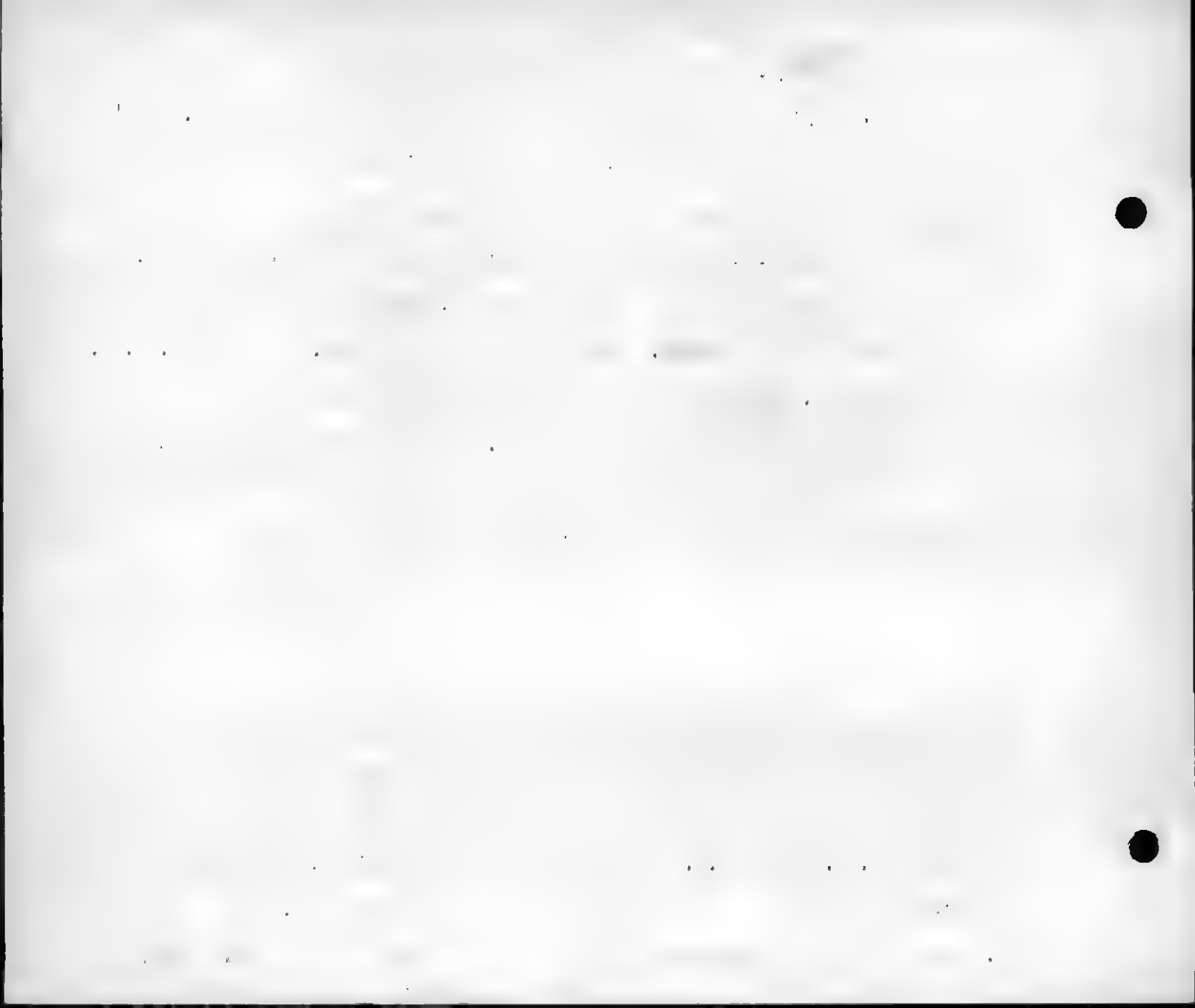
STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7320

CERTIFICATE OF DEATH

07307

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
c. LENGTH OF STAY IN 1b 9hrs.		d. STREET ADDRESS 54 Coral Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Lucille Hodgdon		4. DATE OF DEATH Month Day Year June 5, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1906
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry P. Burroughs		14. MOTHER'S MAIDEN NAME Emma Suite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Natt L. Hodgdon		Address 54 Coral Place Lexington Park,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Intestinal obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal obstruction DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 4, 1960 to June 5, 1960 , that (I) (we) last saw the deceased alive on June 5, 1960 , and that death occurred at 54 Coral Place from the causes and on the date stated above.			
22a. SIGNATURE P. J. Bean		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) P. J. Bean M.D.		22d. ADDRESS Great Mills, Maryland	
23a. BURIAL, CREMATON, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/8/60	
23c. NAME OF Cedar Hill CREMATORY		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland	
25a. REC'D BY REGISTRAR June 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

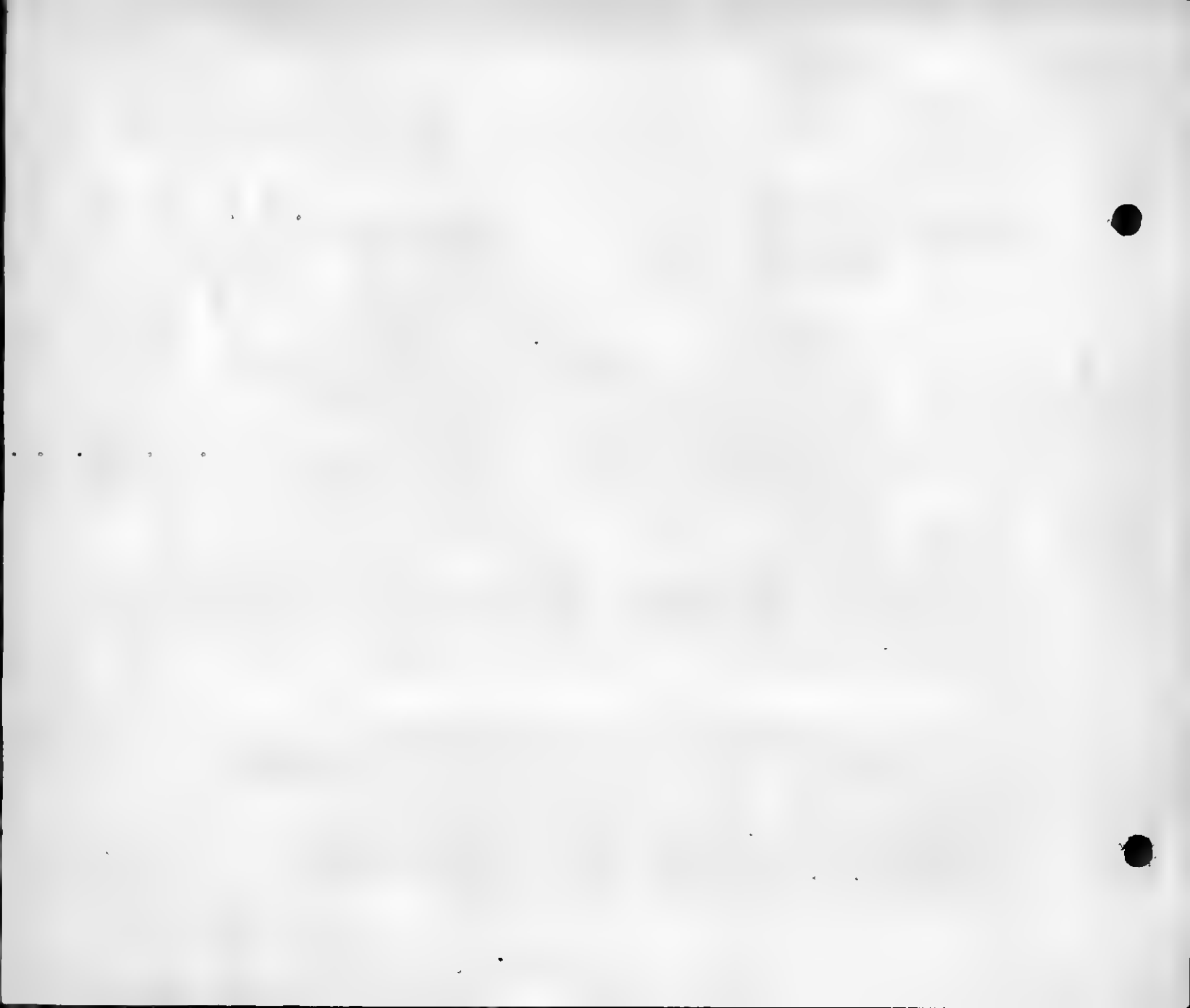
07308

Reg. Dist. No.

7330

1 PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maddox		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mill Point Shores		d. STREET ADDRESS 413 - 17th St. N.E.	
3. NAME OF DECEASED (Type or print) MARGARET JETER		4. DATE OF DEATH June 28 19 60	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Union, South Carolina
13. FATHER'S NAME Austin Jeter		14. MOTHER'S MAIDEN NAME Rosetta Dawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Rosetta Jeter -413-17th St. N.E. Was. D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Small boat turned over			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Small boat turned over	
20c. TIME OF INJURY Month, Day, Year 3:00 p.m. 6-28-60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Wilmington	20f. (City or town) (County) (State) Maddox St Mary Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Wm. D. Boyd, MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Removal		22b. DATE THEREOF 7/1/60	
22c. NAME OF CEMETERY OR CREMATORY Spangler Funeral Home		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE 524 8th N.E. Wash. D.C.		24b. REGISTRAR'S SIGNATURE JUL 5 1960	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-45. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be recorded by the hospital or attending physician.

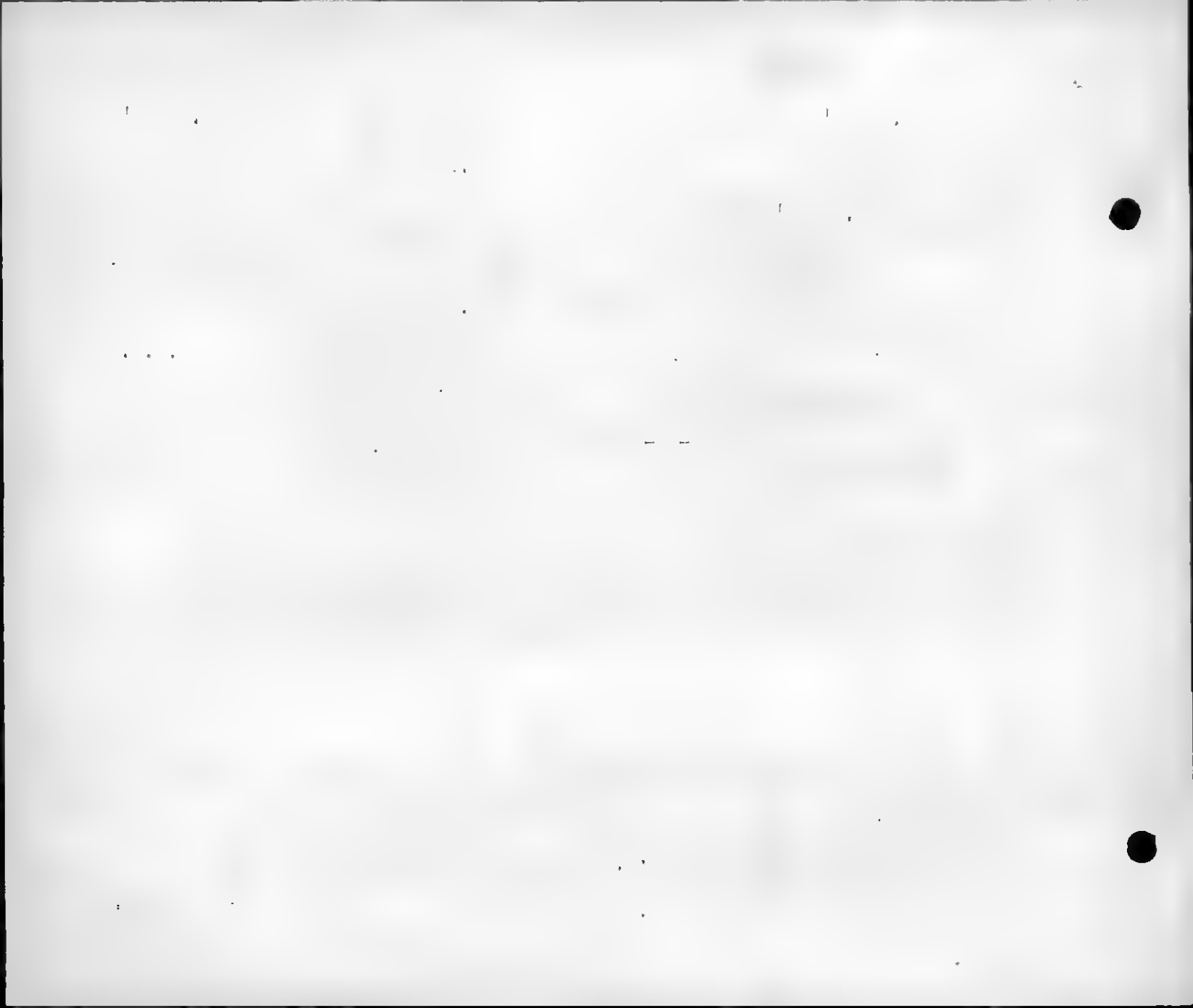
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7321
CERTIFICATE OF DEATH

07309

1 PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b 26days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Mark Last Latham				4. DATE OF DEATH Month June Day 23 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1902	
9. AGE (In years last birthday) 57 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Road				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Martin Latham				14. MOTHER'S MAIDEN NAME Florence Mittingly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 213-22-0622		17. INFORMANT Wilhelmina G. Latham Clements Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary - Infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from May 25, 1960 to June 23, 1960 that (I) (we) last saw the deceased alive on June 23, 1960 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles Greenwell M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Charles Greenwell M.D.				22d. ADDRESS Leonardtwn, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/27/60		23c. NAME OF CEMETERY OR CREMATORY St. Aloysius		23d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtwn, Md				25a. REC'D BY REGISTRAR JUN 28 '60 DATE		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an agent is necessary, it should be executed by the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07310

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hollywood		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Hollywood	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Life		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Philip Herbert Miedzinski		4. DATE OF DEATH Month 6 Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1943
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months 6 Days 22	
11. BIRTHPLACE (State or foreign country) Hollywood		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E Miedzinski		14. MOTHER'S MAIDEN NAME Mary Eva McKay Mary Eva McKay	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. John E. Miedzinski	
17. INFORMANT John E. Miedzinski		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 815X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture skull DUE TO cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Immediate Immediate	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Motor vehicle with bicycle	
20c. TIME OF INJURY Month, Day, Year 8:10 p.m. 6/22/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md. St. Rt. 235		20f. (City or town) (County) (State) Hollywood St. Mary's Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE P. J. Bean		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) P. J. Bean M.D. Great Mills, Md		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/60	
22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or country) (State) Hollywood Maryland	
23. FUNERAL DIRECTOR W.C. Mattingley		24a. REC'D BY REGISTRAR DATE JUN 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanes		24c. ADDRESS Leonardtown, Md	

MEDICAL CERTIFICATION



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived, if not living; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Great Mills		c. LENGTH OF STAY IN IL 1 hr.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS Rural Lexington Park	
3. NAME OF DECEASED (Type or print) XX XX Sylvester Noland		4. DATE OF DEATH June 14, 1960	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1947	
9. AGE (In years last birthday) 12 yrs		10. AGE (If under 1 year) IF UNDER 1 YEAR Months 12 Days 14 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School child		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Duckett		14. MOTHER'S MAIDEN NAME Ethel Noland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethel Noland Lexington Park, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Dr. W. H. PATRICK DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 6-14-60 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Lexington Park, Md. 20f. (City or town) Lexington Park, Md. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. H. PATRICK M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-14-60			
EXAMINER'S NAME (Type) W. H. PATRICK MD Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Face		22d. LOCATION (City, town, or country) (State) Great Mills, Md.	
23. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

VS. A13ME
5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07313

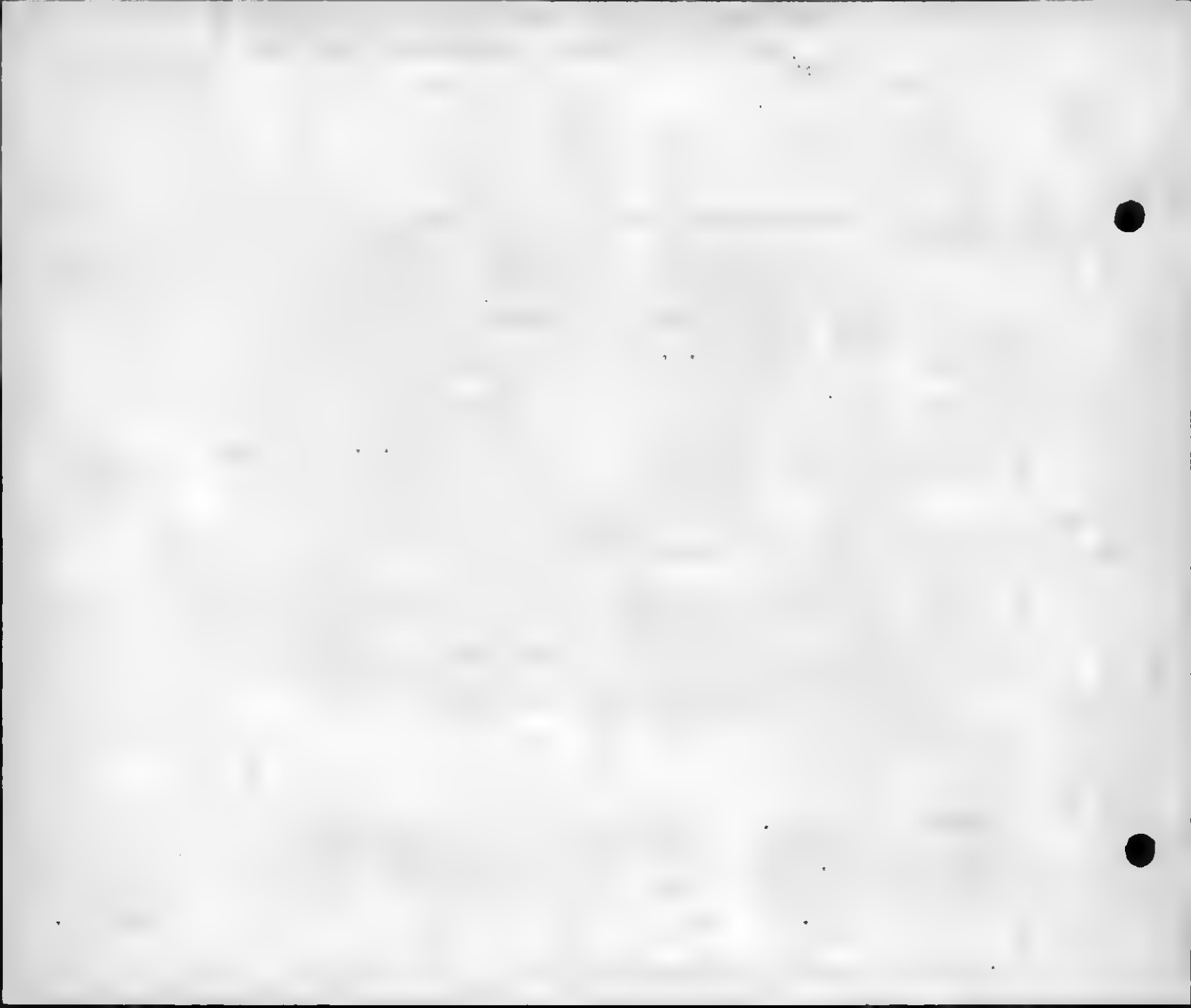
7333

1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, PATUXENT RIVER		c. LENGTH OF STAY IN 1b 21 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X USNAS, PATUXENT RIVER			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNAS (STATION HOSPITAL)				d. STREET ADDRESS PATUXENT RIVER, MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Harry PRIESTER				4. DATE OF DEATH Month Day Year June 7 1960			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-40		9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospitalman		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Edward PRIESTER				14. MOTHER'S MAIDEN NAME Christena (n) VAN TYLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1957/1960 341 32 4531		17. INFORMANT Address Official U.S. NAVY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURE, DEPRESSED, SKULL, COMPOUND, With Immediate 67x DUE TO Brain Injury Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aidman in Crash Ambulance which was struck by aircraft					
20c. TIME OF INJURY Month, Day, Year Hour Minute P. M. 3:50 June 7 1960		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) USNAS		20f. (City or town) (County) PATUXENT RIVER, MARYLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . 3 Stanley D. Harmon							
ACTUAL SIGNATURE Stanley D. HARMON LT (MC) USN				DATE SIGNED 7 June 1960			
EXAMINER'S NAME (Type) Wm D. BOYD MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/60		22c. NAME OF CEMETERY OR CREMATORY ADDRESS W. Clarke Mattingley Leonardtown, Maryland		22d. LOCATION (City, town, or county) (State) Downers Grove, Ill.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR DATE JUN 13 '60		24b. REGISTRAR'S SIGNATURE C. L. S. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please excuse it and indicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

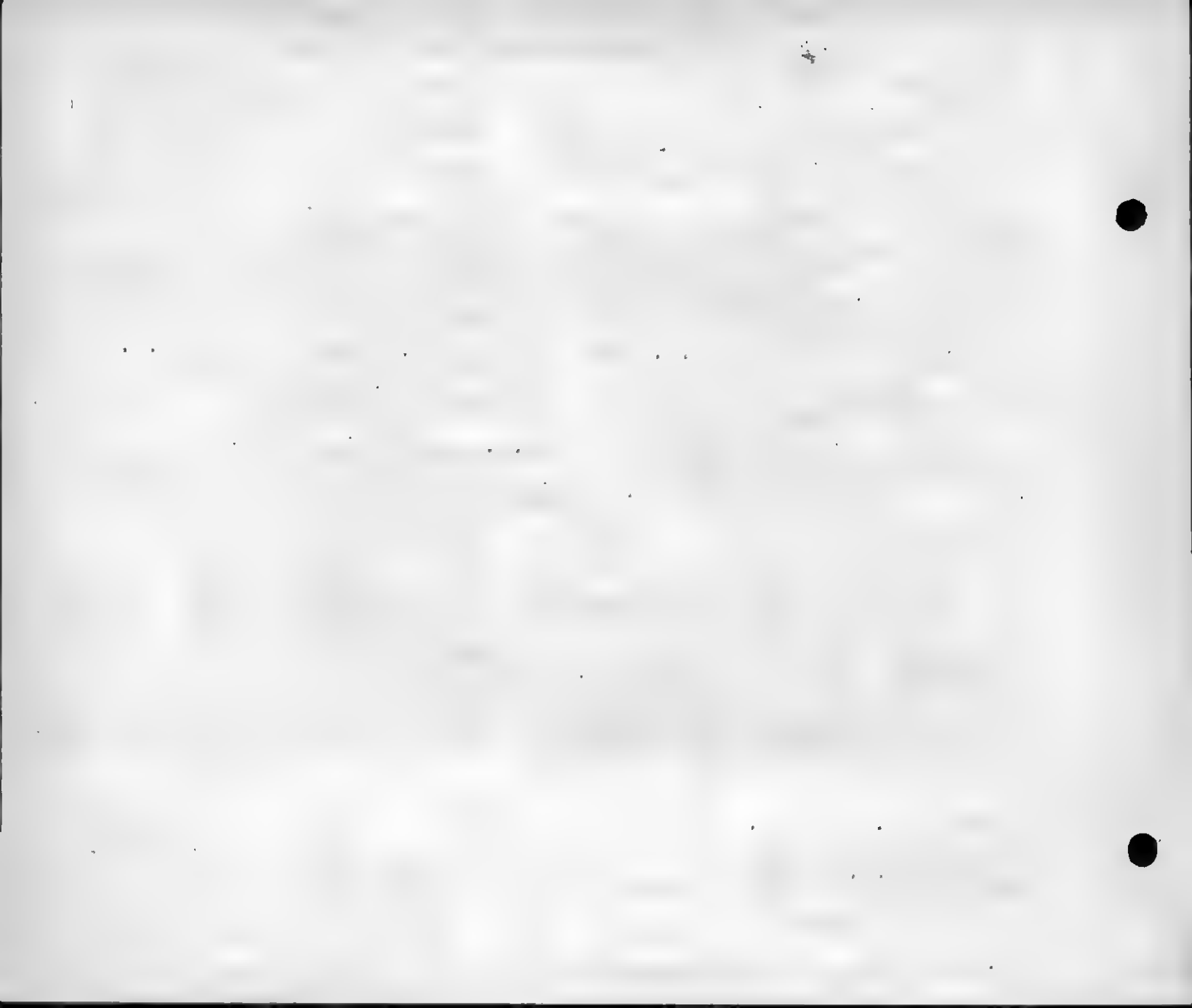
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7334

Reg. 07214

1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park, Maryland				c. LENGTH OF STAY IN IS 1 yr 9 mos			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNAS (STATION HOSPITAL)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Loren Vincent STALTER				4. DATE OF DEATH Month Day Year June 14 19 60			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1941	9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Bremen, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Deceased				14. MOTHER'S MAIDEN NAME Edna Marie VANATTA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 299344478		17. INFORMANT Address U.S. Navy Official Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INJURIES, Multiple Extreme (8651) 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 hrs 9 min
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident					
20c. TIME OF INJURY Month, Day, Year 2040 Hour 2:00 P. M. 6 14 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 235		20f. (City or town) (County) (State) 2 Miles So. Lexington Park, Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Lt. Joseph H. MILLER, III MC, USNR				DATE SIGNED June 14, 1960			
EXAMINER'S NAME (Type) W.H. PATRICK MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/15/60		22c. NAME OF CEMETERY OR CREMATORY Bremen, Ohio		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR JUN 20 1960		24b. REGISTRAR'S SIGNATURE <i>Charles L. Knecht</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7335

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07315

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Indiana b. COUNTY ?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, PATUXENT RIVER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNAS (Station Hospital)		d. STREET ADDRESS 220 N. 16th St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank WILLIAMS		4. DATE OF DEATH Month Day Year June 7 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1930
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Air Force		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace L. Williams		14. MOTHER'S MAIDEN NAME Grace F. (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 6-60	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INJURIES, MULTIPLE, EXTREME 860 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pilot of Air Force Helicopter struck by naval aircraft (F8U).	
20c. TIME OF INJURY Month, Day, Year Hour 3:50 p.m. June 7 1960		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) USNAS, Patuxent River, Md.		20f. (City or town) (County) (State) St. Mary's, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . S.D. HARTON, LT MC USN Station Hospital, USNAS, Patuxent River, Md. DATE SIGNED ACTUAL SIGNATURE M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Wm. D. BOYD MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7 June 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-60	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Cem.		22d. LOCATION (City, town, or county) (State) Richmond Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, 816 H St., NE, Wash. 2		24a. REC'D BY REGISTRAR JUL 11 1960 DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be notified. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 should be detached for use as the burial-transit permit, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7322

CERTIFICATE OF DEATH

07316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Compton</u>	
c. LENGTH OF STAY IN 1b <u>1 hr. 35 min.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>boy</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negroid</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18 1960</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>6</u> <u>35</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Edward Butler</u>		14. MOTHER'S MAIDEN NAME <u>Wilson, Alice Bertina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>773.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>18 June 1960</u> , to <u>18 June 1960</u> , that I last saw the deceased alive on <u>18 June 1960</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mechanicsville, Maryland</u> DATE SIGNED <u>6/18/60</u>			
ACTUAL SIGNATURE <u>Leon W. Berbue</u>		PHYSICIAN'S NAME (Type) <u>Leon W. Berbue M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/21/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>
22d. LOCATION (City, town, or county) <u>Compton</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Hume</u>		DATE <u>JUN 24 '60</u>	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7323
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07317

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown,		c. LENGTH OF STAY IN 1b 1 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Bay Last Young		4. DATE OF DEATH Month June Day 17 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1960
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Benjamin Baker		14. MOTHER'S MAIDEN NAME Alice Elizabeth Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph B. Baker		Address Helen, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subcranial hemorrhage DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/17 19 60 to 6/17 19 60 , that (I) (we) last saw the deceased alive on 6/17 19 60 , and that death occurred at _____ M., from the causes and on the date stated above.			
22a. SIGNATURE Joseph B. Baker		22b. DATE SIGNED 6/20/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Mechanicville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/20/60	
23c. NAME OF CEMETERY OR CREMATORY St. Aloysius		23d. LOCATION (City, town, or county) (State) Leonardtown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR JUN 24 '60	
ADDRESS Leonardtown, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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